FEATURE

Implementing an Incontinence Program:

How one nursing home did it - and the unexpected benefits it brought

JAMIE

LORETTA

Jamie Gitzinger is the administrator of a 120-bed nursing facility, Pine Meadow in Lexington, Kentucky. For our interview about how his incontinence program grew into something greater, he gathered director of nursing Jae Lee, team leader Loretta Johnson, and supply coordinator Tracy Gills to chat with us. Here's how it went:

Vickie: Jamie, I've heard about your CNA team leader program from several individuals here at Medline and even from an outside source. I'm fascinated to learn more about how your facility manages incontinence and how the team approach has affected other areas of care. When did you begin?

Jamie: We started the incontinence program in April 2004. Before that, we had perhaps one or two residents in protective underwear, and everyone else was using briefs.

By Vickie Morris

TRACY

JAE

"We could save money by using more appropriate products - and give better care. A pretty neat concept!"

We knew we could save money by using lighter products for those with less incontinence, and the cost savings was initially the reason to try something new. Today our residents use a variety of pads, liners, and briefs, thus reducing our overall incontinence budget.

Jae: As DON, one of the issues I wanted to address was that most of our residents were in briefs. We were toileting very few residents; the briefs made it difficult. Also, we had residents who didn't want to be in briefs. We wanted to be more conscientious about our residents' incontinence care, and making the change has improved their dignity–how they feel about themselves. They've become more ambulatory. Many more residents are now able to take part in a toileting program.

Vickie: How did you get started?

Jamie: The very first thing we did was to have a thorough in-service with the nursing staff about the new incontinence products. We had to let them know that we were committed to these new products. We were not going to put the products into place and then rip them out six months later if we got a better deal from another vendor! We knew we had many high-functioning residents who were stuck in the wrong product–they could use something different. But we had to start with nursing staff to educate them about the full array of products available. We assured our employees that if they used the right product, it would make their job easier, and it would be better for the resident. Yes, that was the first step; nothing could start without education.

Jae, Tracy, Matt (our sales rep), and I then hand-selected a team of nursing assistants for extra training. Although we call them team leaders now, initially they were called incontinence care professionals or ICPs. They were given purple scrubs to wear once a week to identify themselves as ICPs. These leaders would be available to the floor nursing assistants to help them through the transition–everyone would have someone to go to with questions and concerns. If there was a problem with product application, the ICPs could monitor and review it. We explained to the nursing assistants that the ICPs were given extra education to help them, not to look over their shoulder or criticize. We also explained that we weren't in this to waste money. We thought we could *save* money by using more appropriate products–and give better care. I think the aides and the other staff thought this was a pretty neat concept!

Then we educated the families. We had a family council meeting, and Matt, our sales rep, brought in all the products to show the families. We showed the options and explained that the resident might use something different at night. We talked about how we would distribute the products. The families were very open and even had suggestions for what would be best for their family member. They were glad to play a part in the decision making!

After this, we went around to all the residents and measured and assessed them all over again. We gave the residents information about the new products. We adjusted a few residents at a time from briefs to other products. Not all 120 beds in

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a month! But later, it became second nature for the staff to look at a variety of products for the residents, not just briefs. Since then, with the help of our sales rep, we've gone back every six months to look at each resident again.

Vickie: In theory, having a dozen or more different products for incontinence makes a lot of sense: light products for light incontinence, heavier products for nighttime or heavier incontinence. But administering this type of program in a busy facility sounds difficult. How did you overcome this?

Jamie: Tracy, our supply coordinator, is a key person to our success. She can tell you how she does it!

Tracy: I pass out the products and make sure everyone has what they need. Since storage can be an issue, we created a space at the bottom of every resident's closet for incontinence products. I place stickers inside the closet to tell the aides what product a resident is using during the day, and if they wear a different product at night. So the aides don't have to figure this out. I stock the closets once a week. Basically, the aides know exactly where in the room to look for the products. They're always in the same place.

Jamie: Tracy is full-time on supplies, although occasionally we might use her on a med cart. I think the key to our success in developing this team is that we created a full-time position. In the past, Tracy's job was three days per week. The extra two days have allowed her the time to create communication tools to work with the incontinence teams. The restorative nursing department assesses incontinence for residents. But Tracy assigns the products and sizes. She interviews new residents about their past history and current situation. Then she decides on the product line and measures the resident for sizing. One of the keys has been to show the residents the choices–they will be more satisfied if they have been involved in the process.

> "We now include our team leaders in nursing meetings… where we talk about current issues involving residents."

Tracy: That's right. I feel the residents have more "buy-in" because they can help to choose the products. If they show lesser episodes, they can move into a different product. I have seen that residents are more confident leaving their rooms when they are using the right product.

Jamie: When we first started, we had few residents using protective underwear; everyone was on briefs. We have our share of rehab patients, and these new residents would have some episodic incontinence, but certainly not anything that required a brief. They might have expressed they were having some incontinent issues, and the next thing they knew, they were receiving a brief…probably wearing it and thinking, "Gosh, this is terrible!" We have a lot of rehab residents who return home, and of course we want these residents in particular to remain continent. We are meeting their needs so much better now than before.

Vickie: CMS F315 says to assess, treat, monitor, reevaluate, etc. How has the team approach helped achieve this?

Jamie: Team leaders like Loretta do a vast amount of work in the facility, but one of their key tasks is to oversee the care of the resident in terms of incontinence. If Loretta sees that something needs changing, she

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Jae Lee, DON, and Kim Stephens, Team Leader, take time to visit with a resident in the dining room.

can make that change. If a resident is going through more product, perhaps they need a different one. In the past, by borrowing from another resident, the nursing assistants weren't solving the problem. Now, by communicating with the nursing assistants, Loretta can reevaluate the resident and make a change.

Jae: This is an important concept. Prior to this, there was no system in place to continue to monitor if the chosen products were still doing the job. Now, if someone seems to be wetter than usual, the team leaders will go back and look at how the product has been applied. Proper application is important! We do regular education and review–even between shifts! The team leaders have a communication log to share information between shifts. This is kept with the incontinence products in a locked cage. The extra incontinence products have been locked up, and only the team leaders have the keys. This way, they're always involved when a problem arises or a change is necessary.

Vickie: It sounds like your new program has really improved incontinence care. I can't wait to hear how it grew to involve other areas!

STEPS TO IMPLEMENTING YOUR OWN INCONTINENCE PROGRAM:

1. Educate staff members
2. Select team leaders
3. Hold a family night
4. Develop a supply monitoring system
5. Encourage staff “ownership”of program
6. Celebrate success!

The Team Leader Concept:
An effective framework for more than just incontinence care.

Vickie: When did you start applying the team leader concept on a broader basis?

Jamie: After we saw the difference team leaders were making on the incontinence care products, with such great quality assurance, we knew that leaders like Loretta could educate and support the assistants in other areas. They can be responsible for other areas of patient care and follow up on other resident issues. It's turned into something greater than just working with incontinence and skin care products–it's a real support for the assistants that educates them in all areas! This past year, we changed the title from Incontinence Care Professionals to Team Leaders and gave them a real promotion. They no longer have direct care responsibility. We cover all the shifts seven days a week with CNA team leaders who shadow the four to six assistants on their units–one per unit per shift per day, so every CNA has a team leader to consult with.

Jae: We now include our team leaders in nursing meetings. Every morning they are included in a "24-hour report" meeting where we talk about any current issues involving individual residents. If the issue relates to incontinence or skin, then the team leader makes sure the assistants are notified.

Once a week we have a Standards of Care meeting that the team leaders attend. They get to hear about skin, hydration, weight loss, restraints, or positioning devices. They are then made aware of new orders about mattresses, siderails, safety devices, etc. We have developed a communication tool–a master spreadsheet–so the nursing assistants can see everyone on their unit who may be assigned a safety device or a change in their care plan that would affect the nursing assistant's role.

Vickie: Wow, a CNA with no direct care responsibilities? Was it a difficult decision to add this additional full-time employee to your budget?

Jamie: Believe it or not, it has been a cost savings to add that position! The supervisor can't always be there, but the team leaders can. The team leaders back up the assistants when they go on breaks and make sure they respect their breaks. They make out the daily assignments and know who is most successful where. And simple things like making sure the nursing assistants show up at their meal service times. Team leaders like Loretta can ensure that the aides make the effort required to get the residents' hydration and nutrition needs met. Because she is always on the floor, Loretta can see to it that the residents are comfortable and receiving "top-of-the-line" care. Her responsibilities have changed dramatically.

Loretta: I feel stronger as far as my residents are concerned–I can help them better than in the past. I can get things done the way they are supposed to be done. I feel more important to my residents and the facility. It's a hard job, but I love it! It's rewarding!

Jamie: Loretta has excelled as a team leader. Even before this program, she has always been one of the assistants who lets me or the DON know if a policy is negatively affecting a resident or if a new employee isn't caring for a resident properly. She was already a resident advocate, already a leader. So she was a natural choice when it came to selecting team leaders.

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